

**North Carolina Department of Health and Human Services
Division of Public Health
Women's & Children's Health Section
Nutrition Services Branch
Special Nutrition Programs
CHILD AND ADULT CARE FOOD PROGRAM
ANNUAL APPLICATION**

**ADVANCE PAYMENT REQUEST
(Optional)**

Institution Name: _____ Agreement #: _____
Mailing Address: _____
Street Address: _____
City, State and Zip: _____

Advance payments are administered based on considerations of prior reimbursement claims and/or other information as deemed appropriate with substantiating documentation. By accepting this advance, the Institution agrees that the advance will be recouped in full through claim deductions beginning with the month for which the advance was received. Advance payments will not be made after April 2012. If the Institution's Agreement is terminated and the advance has not been recouped in full as of the date of termination, the Institution agrees that the outstanding advance balance is immediately due and payable to the State Agency.

This advance payment agreement will be effective with respect to meals served during the period commencing the 1st day of _____, 20___, and ending the 30th day of September, 2012.

Signature on Behalf of Institution

State Agency Representative

The undersigned represents the Institution and has the authority to request an advance for and on behalf of said Institution. The undersigned further represents that s/he has read, understands, and agrees to the terms of this request.

By: _____
Signature of SNP Unit Manager

By: _____
(Must be signed by the same person who signs the Agreement)

Date: _____

Title

Date: _____

For State Agency Use Only

Approved for Payment

Initials: _____ Date: _____